



APPOINTMENT OF REPRESENTATIVE AND AUTHORIZATION TO DISCLOSE INFORMATION

BENEFICIARY INFORMATION

Full Name _____

Member Number _____

Address, (please include apt, ste, etc.) _____

Phone # _____

City _____

State _____

ZIP Code _____

Birth Date (mm/dd/yyyy) _____/_____/_____

First Name

Last Name

I appoint _____

to act as my representative in connection with my appeal under 32 CFR 199.10, Appeal and Hearing Procedures. To avoid the possibility of a conflict of interest, I understand that an officer or employee of the United States, to include an employee or member of a Uniformed Service, an employee of a Uniformed Service legal office, a Military Treatment Facility (MTF) or a Health Benefits Advisor (HBA), is not eligible to serve as a representative. An exception to this is made when an employee of the United States or member of a Uniformed Service is representing an immediate family member.

I authorize CHRISTUS Health US Family Health Plan to release to this representative information related to my medical treatment and, if necessary, photocopies of any medical records which may be required for adjudication of my claim for TRICARE benefits.

I understand that this representative shall have the same authority as a party to my appeal and notice given to this representative shall constitute notice to me.

This consent will expire upon the issuance of the final agency decision regarding my appeal; however, I reserve the right to withdraw this authorization at any time.

Signature of Beneficiary Giving Consent

Date

Prohibition on Redisclosure: Further disclosure of information by the appointed representative may only be made in accordance with the provisions of the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable Federal law.

PLEASE RETURN THIS COMPLETED FORM ALONG WITH YOUR APPEAL REQUEST TO:

CHRISTUS Health US Family Health Plan
ATTN: Complaints and Appeals
P.O. Box 169009
Irving, TX 75016
Fax: 866.416.2840

